STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445024	A. BUILDING _____ B. WING _____	01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, JOHNSON CITY	3209 BRISTOL HWY JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure residents were free from restraints for one resident (#108) of fifty residents reviewed. The findings included: Resident #108 was admitted to the facility on January 23, 2009, with diagnoses including End Stage Dementia, Peripheral Neuropathy, Aftercare/healing Trauma Fracture Left Hip, Osteoarthritis, Osteoporosis, Hypercholesterolemia, Diabetes Mellitus type II, Hypertension, Coronary Artery disease, Anxiety, Post-op Anemia, and Insomnia. Medical Record Review of the Care Plan dated December 6, 2012, revealed no interventions for restraint use. Further review of the Care Plan dated December 6, 2012 revealed no interventions for siderails and "...bed to be in the lowest position with mat on floor..." Continued medical record review revealed no documentation of a Physician's Order for the use of the siderails. Observation on January 9, 2013, at10:40 a.m., revealed four side rails in the up position with siderail covers in place. Further observation	F 221	F-221 Resident #108 will not have side rails used as restraints. The Resident Care Coordinator will perform a comprehensive assessment of this resident's mobility and safety devices and ensure the proper devices are in use, without restraining the resident. All residents will be evaluated by the respective Resident Care Coordinator for the potential of side rails being used as restraints. No resident, unless properly assessed, will have all four side rails up. A new side rail assessment will be implemented now, and in conjunction with each resident's quarterly review to ensure side rails are being used appropriately. In-service meetings will be held with nursing staff to review side rail usage. The Resident Care Coordinator will be responsible for reviewing each resident for side rail usage at least quarterly on a routine basis. A review of each resident and their current side rail status, including the corrective actions from this plan of correction, will be presented at the facility's monthly QA meeting in February. The DON, ADON, and Resident Care Coordinators will perform visual audits of each resident's bed rails weekly times two weeks.	2/23/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 2/4/2013

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F 221	Continued From page 1 revealed the resident lying on the left side against the right upper siderail. Interview with Certified Nurse's Assistant #3 and Certified Nurse's Assistant #4, on January 10, 2012 at 8:10 a.m., confirmed the resident was able to roll in the bed and the siderails prevented the resident from rolling out of the bed. Interview with the Resident Care Coordinator (RCC #2), on January 9, 2013, at 10:40 a.m., in the resident's room, confirmed the four siderails were in the up position and the resident was not able to volunatarily able to get out of the bed. Further interview with RCC #2 confirmed the bed was to be in the low position with a mat on the floor at bedside. RCC #2 confirmed the bed was not in the low position. Interview with the Director of Nursing (DON) in the upstairs conference room on January 10, 2013, at 9:45 a.m., revealed the DON stated "...four side rails on the bed were not restraints...the side rails prevented the resident from coming out of the bed...the side rails were split and the resident could get out of the bed between the rails..." Continued interview revealed the DON was not able to say how much distance was between the lower and upper rails. Further interview with the DON confirmed when the definition of a restraint according to federal regulations were explained, the DON confirmed the side rails were a restraint.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		

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F 272	Continued From page 2 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272	F-272 Resident #209 will have an incontinence assessment. The Resident Care Coordinator will review all residents who are incontinent and ensure they have an incontinence assessment. After the discontinued service of an expert incontinence management group, we have updated our incontinence assessment procedure. An updated incontinence assessment will be implemented now for all residents and in conjunction with each resident's admission and annual review by the Resident Care Coordinator. The DON and ADON will each select a sample of five incontinent residents and review their record for an incontinence assessment; weekly times two, and report to next QA committee in February. There will be routine annual reviews by the MDS coordinator and Resident Care Coordinator.	2/23/2013

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F 272	Continued From page 3 Based on medical record review and interview, the facility failed to complete a comprehensive assessment for incontinence for one resident (#209) of fifty residents reviewed. The findings included: Resident #209 was admitted to the facility on August 30, 2012, with diagnoses including Failure to Thrive, Pressure Ulcer on Coccyx, Dementia, Chronic Low Back Pain, Hypothyroidism, and Right Leg Cellulitis. Medical record review of the Urinary Incontinence Assessment and Evaluation Form dated September 6, 2012, revealed "Pt (patient) is frequently incontinent of bladder. Will consult (named incontinence experts)." Additional review of the Urinary Incontinence Assessment and Evaluation Form on September 18, 2012, revealed "Incontinence Management referral to evaluate and treat as needed..." Medical record review revealed a consult was performed on November 1, 2012, by the incontinence group and electronically signed on November 15, 2012. The plan included "perform voiding diary, obtain a void volume with post void residual." Medical record review revealed an order to discontinue the incontinence group on November 15, 2012. Medical record review of the monthly Nursing Summary dated November 28, 2012, revealed, "unable to retrain d/t (due to) impaired cognition."	F 272		

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F 272	Continued From page 4 Interview with Certified Nursing Assistant (CNA# 5), on January 9, 2013, at 12:37 p.m., in nursing station 1, revealed the resident was not capable of physically moving to the bathroom independently, never expressed the need to urinate, and was always incontinent of bowel and bladder. Interview with the Director of Nursing (DON) and the Resident Care Coordinator (RCC #1), on January 9, 2013, at 12:40 p.m., in the conference room, revealed November 1, 2012, was the first visit from the incontinence group and on November 2, 2012, the resident was started on void therapy but "there is no record of it" with the only note being the one dated November 15, 2012. Interview with the DON and RCC #1 on January 9, 2013, at 1:29 p.m., at the Station 1 nursing station, confirmed a comprehensive assessment for bladder incontinence was not completed.	F 272		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement	F 323		

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F 323	Continued From page 5 interventions including assistive devices to reduce the risks of an accident that were consistent with the needs and plan of care for one resident (#108) of fifty residents reviewed. The findings included: Resident # 108 was admitted to the facility on January 23, 2009, with diagnoses including End Stage Dementia, Peripheral Neuropathy, Aftercare/healing Trauma Fracture Left Hip, Osteoarthritis, Osteoporosis, Hypercholesterolemia, Diabetes Mellitus type II, Hypertension, Coronary Artery disease, Anxiety, Post-op Anemia, and Insomnia. Medical record review of the Care Plan dated March 31, 2012, revealed "...Bed in low position, bed alarm, and mat on floor..." Continued medical record review of the Care Plan dated December 6, 2012, revealed "...Bed in low position, bed alarm and mat on floor..." Medical record review of a Physician's Telephone Order dated April 1, 2012, revealed "...Bed/WC (wheel chair) Alarms, low bed (with) floor mat..." Observation of the resident in bed on January 9, 2012, at 2:10 p.m., with LPN #1 revealed no bed alarm in place and the bed in a raised position and not in the low position. Continued observation on January 10, 2013, at 8:05 a.m., revealed the resident in bed with the bed in a raised position. Interview with LPN #1 on January 9, 2013, at 2:20 p.m., in the upstairs conference room confirmed the bed alarm was not in place.	F 323	F-323 Resident #108 will have bed alarm in place and the bed in low position as care planned. All residents will be evaluated by the respective Resident Care Coordinator for the potential of safety devices not being used as care planned, and will ensure the appropriate, care-planned device(s) are in use. In-service meetings will be held with nursing staff on the proper use of assistive devices used to reduce the risks of accidents. The licensed nurse assigned to each shift will be responsible for checking each resident's safety devices at least once per shift and communicating each resident's plan of care to the respective CNA each shift. The Resident Care Coordinator will perform audits weekly times three weeks of all patients to ensure safety devices are in use as care planned. DON or designee will perform monthly checks of all residents with safety devices and report to monthly QA committee.	2/23/2013

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F 323	Continued From page 6 Interview with LPN #1 on January 10, 2013, at 8:05 a.m., in the resident's room confirmed the bed was not in the low position.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the accurate acquiring, receiving, dispensing and administering of a medication for one (#172) of fifty sampled residents. The findings included:	F 425		

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F 425	Continued From page 7 Resident #172 was admitted to the facilty on June 25, 2012, with diagoses including Parkinson's Disease, Coronary Artery Disease, Long-Term Coumadin Therapy, Congestive Heart Failure, Chronic Renal Failure, Acute Anxiety, Dementia, Depression, and Insomnia. Medical record review revealed a Physician's Order dated June 25, 2012, for Clonazepam (Klonopin, an antianxiety) 0.5 mg. every twelve hours for anxiety. Medical record review of a Medical Psychiatry Evaluation dated October 10, 2012, revealed the resident was currently on Clonazepam 0.5 mg. twice daily for anxiety. Further review revealed, "...add PRN (as needed) of Clonazepam 0.5 mg. every 12 hours for increased anxiety." Medical record review of the November Physician's Recapitulation (recap) Orders revealed the order for Clonazepam 0.5 mg. every 12 hours as needed (PRN) for acute anxiety however, the Physician's Order no longer reflected the routine order for Clonazepam 0.5 mg. twice daily. Further review of the Physician's Recap Orders for December 2012 and January 2013, revealed no order for the routine order for Clonazepam 0.5 mg. twice daily. Review of the Medication Administration Records (MAR) for October, November, December 2012 and January 2013, revealed the resident continued to receive Clonazepam 0.5 mg. every 12 hour at 8:00 a.m. and 8:00 p.m. documented as "every 12 hours as needed" with no further dosages given.	F 425	F-425 All klonopin orders for resident #172 have been reviewed with the doctor and psychiatric NP for clarification of use; all klonopin orders have been discontinued. All of resident #172 medications have been reviewed to ensure the correct medications are being administered. All residents on klonopin will be reviewed by the Resident Care Coordinator for order and administration accuracy. Licensed nurses will be in-serviced on medication order transcription as related to electronic MAR procedures. A 24-hour order-check procedure will be implemented. The DON, ADON, and Resident Care Coordinator will perform weekly audits of a sample of residents on each unit for three weeks to ensure medications are being administered and documented as ordered. Monthly monitoring by the consultant pharmacist will focus on this issue and be reported to the QA committee.	2/23/2013

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F 425	Continued From page 8 Medical record review of a Physician's Order dated January 4, 2013, revealed "d/c (discontinue) Klonopin 0.5 mg. bid PRN due to disuse." Review of the MAR dated January 2013, revealed the resident received a Clonazepam 0.5 mg. on January 4, 2013, at 8:00 a.m., and the medication was then discontinued. Observation on January 9, 2013, at 2:00 p.m., revealed the resident sitting quietly in a broda chair in the resident's room. Interview with the Psychiatric Nurse Practitioner at the 200 Hall Nursing Station on January 9, 2012, at 2:30 p.m., confirmed the resident was to have remained on Clonazepam 0.5 mg. twice daily and only the PRN dosages were to be discontinued. Telephone interview with the Pharmacist on January 10, 2013, at 10:00 a.m., confirmed the Physician's Recap Orders are sent to the facility by the pharmacy and the MARs are printed from the Physician's Recap Orders. Further interview confirmed no order had been received to discontinue the routine Clonazepam 0.5 mg. twice daily, and the order should have been included on the Physician's Recap Orders and the MARS in November and December 2012 and January 2013. Interview with the 300 Hall Resident Care Coordinator on January 10, 2013, at 10:10 a.m., confirmed the resident had not received Clonazepam 0.5 mg. since January 4, 2013, at 8:00 a.m.	F 425		

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F-441 Hand hygiene during ice pass, and while under isolation precautions, was immediately reviewed with all staff working during this time. All residents who receive a water pitcher have the potential to be affected. Hand hygiene while passing ice will be reviewed with all staff at in-service meetings. In the event of another general isolation precaution of all patients due to a virus, hand hygiene procedures for passing ice will be specified to all staff in written and verbal reminders by the infection control nurse. The infection control nurse will perform monitoring of ice passes on each unit weekly times three weeks, then report to QA committee for continued monitoring recommendations.	2/23/2013

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F 441	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure staff disinfected hands during the ice pass to the residents. The findings included: Observation on January 9, 2013, revealed on the 200 hall several residents had a virus and the facility was using isolation precautions for everyone. Observation on January 9, 2012, at 9:30 a.m., in the 200 hall, revealed two CNA's (certified nursing assistant) filling the resident's water pitchers with ice. Continued observation revealed CNA #1 entered room 205, obtained resident A bed's water pitcher, returned to the ice chest, filled the water pitcher with ice, returned to the resident's room, retrieved B bed's water pitcher, returned to the ice chest, placed the water pitcher on the ice chest, filled the water pitcher with ice, and returned the water pitcher to the B bed's room. Continued observation revealed CNA #2 went into room 206, obtained the water pitcher and continued to proceed in the same procedure as CNA #1. Continued observation revealed CNA #1 and #2 entered room 203 with one resident and enter 204, with one resident, entered room 202, with one resident, entered room 201, with two residents. Continued observation revealed the CNA's did not disinfect the hands after each resident's water pitcher was filled with ice. Review of facility policy, Handwashing/Hand	F 441		

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F 441	Continued From page 11 Hygiene, revealed "...e. before and after entering isolation precaution setting...6. i. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident..." Interview with the CNA #1 and #2 on January 9, 2013, at 9:45 a.m., in the 200 hallway, confirmed the CNA's had not disinfected the hands after each resident's water pitcher was filled with ice. Interview with the Assistant Director of Nursing on January 10, 2013, at 10:15 a.m., in the 400 hallway, confirmed the staff are to disinfect hands after each patient. Continued interview confirmed staff are not to place the resident's water pitchers on the ice chest.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a laboratory test as ordered by the physician timely. The findings included: Resident #172 was admitted to the facility on June 25, 2012, with diagoses including Parkinson's Disease, Coronary Artery Disease, and Long-Term Coumadin Therapy. Medical record review revealed a protime was	F 502		

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F 502	Continued From page 12 obtained on November 28, 2012, with INR (International Normalized Ratio) result of 5.3. Orders received were to hold Coumadin for two days and start alternating dosage, every other day of 2.0 mg. and 2.5 mg., and recheck INR in two days. Medical record review revealed no documentation the protime was obtained on November 30, 2012, as ordered. Further review revealed the next protime was obtained on December 5, 2012, (seven days from order received on November 28, 2012). Medical record review of the December 5, 2012, protime/INR result was 2.8, with orders to hold Coumadin for one day and repeat lab in one week. Interview with the 300 Hall Licensed Practical Nurse Supervisor at the 300 Nursing Station on January 9, 2013 at 2:15 p.m., confirmed the protime had not been obtained as ordered by the physician.	F 502	F-502 Lab orders for resident #172 were clarified with the attending physician and the resident's labs have been obtained as ordered. All residents with orders for INR labs will be reviewed routinely for accuracy: daily and weekly by the shift nurse and no greater than weekly by the Resident Care Coordinator. INR labs will be monitored in three systems: lab calendar, lab log, and electronic MAR. The respective Resident Care Coordinator will monitor each resident with INR labs twice per week for three weeks and report to QA committee for further monitoring recommendations.	2/23/2013
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445024	A. BUILDING _____ B. WING _____	01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, JOHNSON CITY	3209 BRISTOL HWY JOHNSON CITY, TN 37601

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F 514	Continued From page 13 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain an accurate clinical record for one (#172) of fifty sampled residents. The findings included: Resident #172 was admitted to the facilty on June 25, 2012, with diagoses including Parkinson's Disease, Coronary Artery Disease, Long-Term Coumadin Therapy, Congestive Heart Failure, Chronic Renal Failure, Acute Anxiety, Dementia, Depression, and Insomnia. Medical record review revealed a Physician's Order dated June 25, 2012, for Clonazapam (Klonopin, an antianxiety) 0.5 mg. every twelve hours for anxiety. Medical record review of a Medical Psychiatry Evaluation dated October 10, 2012, revealed the resident was currently on Clonazepam 0.5 mg. twice daily for anxiety. Further review revealed, "...add PRN (as needed) of Clonazepam 0.5 mg. every 12 hours for increased anxiety." Medical record review of the November Physician's Recapitulation (recap) Orders revealed the order for Clonazepam 0.5 mg. every 12 hours as needed (PRN) for acute anxiety however, the Physician's Order no longer reflected the routine order for Clonazepam 0.5	F 514	F-514 All klonopin orders for resident #172 have been reviewed with the doctor and psychiatric NP for clarification of use; all klonopin orders have been discontinued. All of resident #172 medications have been reviewed to ensure the correct medications are being administered and documented correctly. All residents on klonopin will be reviewed by the Resident Care Coordinator for order, administration, and documentation accuracy. Licensed nurses will be in-serviced on medication order transcription as related to electronic MAR procedures. A 24-hour order-check procedure will be implemented. The DON, ADON, and Resident Care Coordinator will perform weekly audits of a sample of residents on each unit for three weeks to ensure medications are being administered and documented as ordered. Monthly monitoring by the consultant pharmacist will focus on this issue and be reported to the QA committee for further monitoring recommendations.	2/23/2013

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F 514	Continued From page 14 mg. twice daily. Further review of the Physician's Recap Orders for December 2012 and January 2013, revealed no order for the routine order for Clonazepam 0.5 mg. twice daily. Review of the Medication Administration Records (MAR) for October, Noverr ber, December 2012 and January 2013, revealed the resident continued to receive Clonazepam 0.5 mg. every 12 hour at 8:00 a.m. and 8:00 p.m. documented as "every 12 hours as needed" with no further dosages given. Medical record review of a Physician's Order dated January 4, 2013, revealed "d/c (discontinue) Klonopin 0.5 mg. bid PRN due to disuse." Review of the MAR dated January 2013, revealed the resident received a Clonazepam 0.5 mg. on January 4, 2013, at 8:00 a.m., and the medications was then discontinued. Interview with the Psychiatric Nurse Practitioner at the 200 Hall Nursing Station on January 9, 2012, at 2:30 p.m., confirmed the resident was to have remained on Clonazepam 0.5 mg. twice daily and only the PRN dosages were to be discontinued. Telephone interview with the Pharmacist on January 10, 2013, at 10:00 a.m., confirmed the Physician's Recap Orders are sent to the facility by the pharmacy and the MARs are printed from the Physician's Recap Orders. Further interview confirmed no order had been received to discontinue the routine Clonazepam 0.5 mg. twice daily, and the order should have been	F 514		

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F 514	Continued From page 15 included on the Physician's Recap Orders and the MARs in November and December 2012 and January 2013. Interview with the 300 Hall Resident Care Coordinator on January 10, 2013, at 10:10 a.m., confirmed the resident's Physician's Recap Orders and MARs for November and December 2012 and January 2013 were incorrect	F 514		